

**MTS**

Multi-Therapeutic Services, Inc.

4201 Connecticut Avenue, NW, Suite #405, Washington, DC 20008

**FAX COVER SHEET**

FAX NO.: (202) 244-8048

DATE: 9/21/07TO: Sheila Pennell, DOHCOMPANY/AGENCY: DOH/HRAFAX NO.: 202-442-9430

NO. OF PAGES TRANSMITTED (INCLUDING COVER SHEET) \_\_\_\_\_

MESSAGE: Please see attachedFROM: John Gray PHONE NO.: (202)244-4500

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PRINTED: 09/21/2007  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/13/2007
NAME OF PROVIDER OR SUPPLIER  M T S			STREET ADDRESS, CITY, STATE, ZIP CODE  927, 55th Street N.E. Washington, DC. 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
1000	INITIAL COMMENTS  A licensure survey was conducted on September 13, 2007. The facility's bed capacity was six. According to the facility's management five clients were scheduled to transfer to the home upon the approval for licensure. The findings of the survey were based on observation and staff interviews.	1000			
1082	3503.10 BEDROOMS AND BATHROOMS  Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.  This Statute is not met as evidenced by: Based on observation the facility failed to ensure that bathrooms be equipped with a cup dispenser and toilet paper holder.  The finding includes:  Observations of the facility's environment on September 13, 2007 revealed that there was no cup dispenser, and toilet paper holder.	1082	The toilet paper holder and cup dispenser is at the clay home and will be brought to 55th Street when the individuals move in.	9/26/07	

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

M41711

If continuation sheet 1 of 1